	MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM  PATIENT AND INSURED (SUBSCRIBER) INFORMATION  8 1. PATIENT'S NAME (First, middle, last)  2. DATE OF BRTH  2. DATE OF BRTH  2. DATE OF BRTH  2. INSURED'S NAME (First rame, middle infed, last rame)  SAME (First rame, middle infed, last rame)
	A. PATIENT'S ADDRESS (Shoot, City, Shate, Zip Coda) S. INSURED'S SEX.  S. PATIENT'S SEX.
	SELF SPOUSE CHILD OTHER  SELF SPOUSE CHILD OTHER
	O . OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy or Plate Holder, Plan Name and Address, and Policy or Partie. TS X X VICTIM  11. INSURED'S ADDRESS (Street, City, State, Zip Code)  12. INSURED'S ADDRESS (Street, City, State, Zip Code)  13. INSURED'S ADDRESS (Street, City, State, Zip Code)  14. INSURED'S ADDRESS (Street, City, State, Zip Code)
	ACCIDENT X OTHER LABILITY  12. DATE 13.
	PATIENT'S OR AUTHORIZED SIGNATURE MM DD YY INSURED'S SIGNATURE
	PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)  14.DATE OF CONSET OF CONSIDER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)  14.DATE OF CONSTION OF STREET CONSULTED INFORMATION OF STREET AND SAME OF SUPPLIER INFORMATION OF STREET AND SAME OF SUPPLIER INFORMATION OF STREET AND SAME OF SUPPLIER INFORMATION OF SUPPLI
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	20. NATIONAL DRUG CODE 20A.UNIT 20B.QUANTITY 20C.COST INDC info entered to this talk of this fall will be a considered in the set of the contract to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of this fall will be a considered to the talk of talk of the talk of talk of talk of the talk of tal
	21.NAME OF RACILITY WHERE SERVICES RENDERED (f other than home or office) 21.A ADDRESS OF FACILITY 22. WAS U ANN. CFT W. X. PERFORMED LAB CHARGES OF SERVICES RENDERED (f other than home or office)
	22A. SERVICE PROVIDER NAME  22B. PROF CD  22C. IDENTIFICATION NUMBER
	23. DAGNOSIS OR NATURE OF LINESS. RELATE DAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX COCC 22F. Y N 22H. Y N POST NE. Y N EMBLY. Y N FAMILY. Y N POST NE.
(PERF)	2. 2. A PRIVATE SURCE CD 2. MILION MI
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	THROUGH SCC CD BOUND
	25. GERIFICATION ON THE PROPERTY OF THE STATEMENTS ON THE PROPERTY OF THE BILL  AND ARE MADE A PARTH HEREOF)  26. ANDUNT PAID  27. TOTAL CHARGE  28. AMOUNT PAID  29. BALANCE DUE  (AND ARE MADE A PARTH HEREOF)
i	20. EMPLOYER IDENTFICATION NUMBER/ SIGNATURE OF PHYSICIAN'S OR SUPPLIERS NAME, ADDRESS, ZIP CODE SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNATURE OF PHYSICIAN OR SUPPLIERS NAME, ADDRESS, ZIP CODE
	258. MEDICALD CONTROL NUMBER
	25. DATE SIGNED  25. DATE SIGNED  25. DATE SIGNED  26. PATIENT'S ACCOUNT NUMBER  DO NOT WRITE IN THIS SPACE.  (9/10) EMEDNY-150003  33. OTHER REJ. FRINS ORDERING PROVIDER  134. PROF CD 135. CASE MANAGER ID

## 2.3 Certification

Provider certifies that: I am (or the business entity named on this form of which I am a partner, officer or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the person(s) providing services, care or supplies have the required licensing, certification and training. I have reviewed this form; I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized and I or the entity make this claim in accordance with applicable federal and state laws and regulations. I certify that the services were rendered at the location listed in the "place of service field" and that such location has been entered on the claim. I HAVE READ THE MEDICAID MANAGEMENT INFORMATION SYSTEMS PROVIDER MANUAL AS IT RELATES TO THE CLAIM FORM, AND ALL REVISIONS AND UPDATES THERETO; ALL CLAIMS ARE MADE IN FULL COMPLIANCE WITH THE PERTINENT PROVISIONS OF THE MANUAL, REVISIONS AND UPDATES; ALL CLAIMS FOR CARE SERVICES AND SUPPLIES PROVIDED AT THE ORDER OF ANOTHER PROFESSIONAL HAVE TO THE BEST OF MY KNOW-LEDGE BEEN ORDERED BY THAT PROFESSIONAL IN BONA FIDE COMPLIANCE WITH THE PROCEDURES SET FORTH IN THE MANUAL, REVISIONS, OR UPDATES AND ALL FEDERAL AND STATE LAWS AND REGULATIONS. ALL CARE, SERVICES, AND SUPPLIES FOR WHICH CI MADE ARE MEDICALLY NECESSARY FOR THE TREATMENT OF THE NAMED RECIPIES amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my is payable from any source other than, the Medical Assistance Program; payment of fees made in with established schedules is accepted as payment in full; other than a claim rejected or der adjustment, no previous claim for the care, services and supplies itemized has been sub STATEMENTS MADE HEREON ARE TRUE, ACCURATE AND COMPLETE TO KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FOR THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM I LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPL STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUM A MATERIAL FACT; taxes from which the State is exempt are excluded ining to the care, services and supplies provided including all records which are neces v the extent of care. services and supplies provided to individuals under the New York stance Program will be kept for a period of six years from the date of payment, and such nation regarding this claim and payment therefor shall be promptly furnished upon request to services district or the New York State Department of Health, the State Medicaid Fraud Contr Secretary of the Department of Civil Rights Act of 1964 and with Health and Human Services; there has been compliance with section 504 of the Federal Rehabilitation Act of 1973, as amo which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and re (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclo s; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make a corrections to this claim to enable its automated processing subject to reversal by provider, as claim data on this form as original evidence of care, services and supplies furnished.

r the entity) shall be subject to and bound by all laws, By making this claim I understand and as rules, regulations, policies, standards cedures of the United States Department of Health and Human Services, the New York ent of Health (Department) and other publications of the Department, including Medicaid rmation System Provider Manuals and other official bulletins of the Department or any other la lation, policy, procedures of any other state agency which governs the provision of or billing for car es or supplies which are reimbursed under the Medical Assistance Program for the State of New nderstand and agree that I (or the entity) shall be subject to and shall accept, subject to due process whaw, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, p e status in the Medicaid program and/or imposing any duly considered sanction or penalty. I fu I have complied with the billing requirements of the United States Department of Health and ces and the Department including but not limited to the following: If I am billing r (individual practitioner or business entity which is not required to enroll as a group), services or supplies were provided by me except in situations where care, services or d: (a) under a locum tenens agreement or (b) by a physician's assistant or certified social er my supervision, and that my provider identification number is being used on the claim am required to bill as a group provider, I certify that the care, services or supplies were provided that the provider identification number of the group is being used on the claim for payment, and vider identification number of the individual who provided the service has been entered on the claim.

understand that my signature on the face hereof incorporates the above certifications and attests to their truth.

2~48 (Rev. 10/96)